Case Number:	CM13-0067451		
Date Assigned:	01/03/2014	**Date of Injury:**	01/05/2011
Decision Date:	04/25/2014	**UR Denial Date:**	12/09/2013
Priority:	Standard	**Application Received:**	12/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 55-year-old who reported an injury on January 5, 2011. The mechanism of injury was being struck in the face by a piece of sheet metal. He subsequently suffered a broken tooth, broken nasal bones, head and neck pain, and bilateral shoulder injuries. The patient later sustained another industrial injury in December of 2011 that again fractured nasal bones, and aggravated his bilateral shoulders. Prior to the second injury, the patient received an MRI of the cervical spine that revealed congenital spinal canal narrowing and disc extrusions at C4-5 and C5-6. There was borderline cord compression noted at the C5-6 level with additional annular bulges at C3-4 and C6-7. The patient's treatment to date is unclear; however, it is noted that he received a cervical epidural steroid injection on March 20, 2013 with no report of symptom relief. He also received an EMG/NCV (electromyography/nerve conduction velocity exams) on July 30, 2012 that revealed severe bilateral carpal tunnel syndrome affecting both the sensory and motor components. The patient has been placed on multiple medications to help control his pain and increase his function, and received an unknown duration of physical therapy. As the patient has failed a significant amount of conservative care since the time of injury, his treating physician has been attempting to obtain a surgical consult for the cervical spine as well as a dental consult. Until that can be completed, the patient continues to utilize pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

NUCYNTA 50 MG, 60 COUNT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend opioids to treat moderate to severe chronic pain. Guidelines state that pain assessments should be performed at each visit, functional measurements should be obtained at six months intervals using a numerical scale or validated instrument, and random urine drug screens should be performed to monitor patient compliance. The pain assessments should include the patient's current pain levels, the least reported pain since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief to begin, and how long the pain relief lasts. The clinical information submitted for review did have updated functional measurements; however, there was no inclusion of a urine drug screen, or thorough pain assessment. In fact, none of the records submitted for review provided a current pain level for the patient, or pain levels in regard to medication use. There was a simple statement in multiple updated clinical notes that stated the patient's pain without medications is 9/10, but did not address pain with medication use. In addition, the patient's functional measurements remained unchanged from the visits prior to Nucynta prescription, to those visits after Nucynta use began. As the clinical note dated November 22, 2013 stated that the patient reported the Nucynta helped decrease his pain, it appears that the patient has been utilizing this medication although it has not been certified. As such, there should be documentation regarding the medication's effect on the patient's functional abilities and pain levels. As previously stated, there were no pain levels provided in direct response to the medication use, and functional measurements remained unchanged since prior to the Nucynta use. Furthermore, the records indicate that the patient is utilizing this medication on an as needed basis; however, there was no discussion within the medical records reviewed, regarding the patient's actual frequency of use. Without objective documentation to support the efficacy of this medication, continuation is not recommended at this time. However, it is noted that opioids are not recommended for abrupt discontinuation, and therefore, it is expected that the physician allow for safe weaning. The request for Nucynta 50 mg, 60 count, is not medically necessary or appropriate.